DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th day 8-3-19 / 70th 8-28-19

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"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs POC #1	PROVIDER # 445491	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 6/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKENDREE VILLAGE	4347 LEBANON ROAD HERMITAGE, TN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to capture a fall on the Quarterly Minimum Data Set (MDS) for 1 of 58 residents (#73) reviewed. The findings include: Medical record review revealed Resident #73 was admitted to the facility on 11/30/16 with diagnoses which included Chronic Obstructive Pulmonary Disease, Anxiety and Muscle Weakness. Medical record review of the facility investigation dated 12/5/18 revealed Resident #73 had a fall. Medical record review of the Quarterly MDS dated 1/30/19 revealed an uncaptured fall. Interview with Registered Nurse (RN) (MDS) #7 on 6/19/19 at 6:08 PM and 6:48 PM in the dining room revealed "...there was some type of glitch with the system..." Continued interview confirmed RN #7 did not capture the fall for Resident #73 on the Quarterly MDS dated 1/30/19. Interview with the Administrator on 6/19/19 at 7:34 PM in the conference room confirmed "...I expected the fall to be captured not immediately but on the next assessment due..."

F641

Please See Below

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein/ To continue to remain substantial compliance with 42 CFR Part 482.13., Requirements for Long Term Care Facilities, McKendree Village has taken or will take the actions set forth in the plan of correction.

F641 Accuracy of Assessments

The facility has and will continue to ensure that assessments accurately reflect the residents' status. The Quarterly MDS Assessment for resident # 73 was corrected on 6/19/19 and submitted on 6/20/2019. On or before 6/25/19, 2019, the Health Center MDS Nurses will attend an in-service. The in-service will be conducted by the Administrator or Designee, and will include:

- Review of the regulation.
- Review of the statement of deficiency.
- Review of the plan of correction.
- Completing accurate MDS assessments for residents following the RAI Manual and facility policy on Comprehensive Assessments.

An audit of all quarterly MDS assessments completed in the previous 90 days was conducted to assure each assessment accurately reflected the status of the residents. A corrected MDS will be completed if any discrepancies are identified. Residents who have a change in condition will be discussed during the Interdisciplinary Team meetings with the MDS nurse present. The MDS nurse will document any changes discussed to ensure they are captured on the next assessment. Beginning 7/23/2019, the Administrator or Designee will monitor MDS assessments for continued compliance through the Quality Improvement audits (see Attachment A). The audits will be completed weekly for one month and monthly for one quarter. The Administrator or Designee will report to the Quality Assurance Performance Improvement Committee who will determine the frequency and number of further monitoring.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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	445491	A. BUILDING _____ B. WING _____	06/19/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigations #47809, #47967, #48006, and #48010 were completed on 6/19/19 at McKendree Village. Deficiencies were cited related to the recertification survey and complaint investigation #48006 under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review and interview, the facility failed to protect Resident #130 from physical abuse by a facility Certified Nurse Technician (CNT). The findings include: Facility policy review, Abuse Prevention/Reporting Policy and Procedure, updated 5/9/18, revealed "...Every resident has the right to be free from	F 600	**F600 Freedom from Abuse, Neglect and Exploitation** McKendree Village has and will continue to ensure that residents are free from abuse, neglect, misappropriation of property and exploitation. Resident 130 was assessed on 6/1/19 by the DON and by the Nurse Practitioner on 6/3/19. The care plan for resident # 130 was updated to reflect the resident's behavioral needs on 6/1/19. The resident continues to reside in the facility and is doing well. On or before 7/12/2019, the Health Center staff will attend an in-service. The in-service will be conducted by the DON Administrator or Designee, and will include: • Review of the regulation. • Review of the statement of deficiency. • Review of the plan of correction. • Review of the facility Abuse Recognition and Prevention Policy McKendree Village will continue to screen potential employees for abuse before hire. Staff will continue to be in-serviced during orientation, at least yearly thereafter, and as needed on the facility's policy regarding Abuse Recognition and Prevention and the requirement for reporting any allegation of abuse to the Abuse Coordinator immediately for investigation	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sylvia J. Burton RN, NHA	Interim Administrator	7/11/2019

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F 600	Continued From page 1 abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to employees, other residents, physicians, consultants, volunteers, family members, legal guardians, friends or other individuals...the facility has developed and instituted policies and procedures for screening and training employees in regard to the protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment and misappropriation of property..." Facility policy review, Resident Rights, revised December 2016, revealed "...Employees shall treat all residents with kindness, respect, and dignity..." Review of the facility's investigation dated 6/1/19 revealed Licensed Practical Nurse (LPN) #3 witnessed CNT #5 slap the back of Resident #130's arms. Continued review revealed the facility conducted a thorough investigation resulting in suspension and termination of CNT #5 related to the allegation. Review of the Incident/Accident Report dated 6/1/19 revealed Resident #130 "...skin unremarkable..." Medical record review revealed Resident #130 was admitted to the facility on 7/21/16 with diagnoses which included Dementia Without Behavioral Disturbances, Restless and Agitation, Hallucinations, Alzheimer's Disease, Anxiety Disorder, Unspecified Osteoarthritis, Unspecified	F 600	Beginning 7/23/2019, the Administrator or Designee will monitor for continued compliance through the Quality Improvement audits (see Attachment B). The audits will be completed weekly for one month and monthly for one quarter. The Administrator or Designee will report to the Quality Assurance Performance Improvement Committee who will determine the frequency of further monitoring.	7/23/2019

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F 600	Continued From page 2	F 600		

Mental Disorder Due to Known Physiological Condition, and Major Depressive Disorder.

Medical record review of the Annual Minimum Data Set (MDS) dated 6/3/19 revealed Resident #130 was rarely/never understood. Further review revealed Resident #130 required total assist with one person with bed mobility, dressing and personal hygiene.

Medical record review of the Medical Physician Progress Note dated 6/3/19 for Resident #130 revealed "...does not have any bruises consistent with an injury...unable to provide any history due to advanced dementia...appears comfortable..."

Medical record review of the Psychiatric Physician Progress Note dated 6/3/19 for Resident #130 revealed "...patient to be seen due to an alleged altercation between patient and a tech...Patient smiling. No marks on patient noted. Patient not acting as if had been traumatized or is in fear or scared. No stress reaction noted. Patient most likely does not have any memory of event is clearly showing no signs of lasting trauma..."

Review of CNT #5's employee record revealed CNT #5 was not on the abuse registry and trained in abuse on 5/9/19. Further review revealed CNT #5 was suspended on 6/1/19 and terminated from the facility on 6/14/19.

Review of In-services/trainings dated 6/1/19, 6/2/19, 6/3/19 and 6/4/19 revealed facility educated staff on abuse/neglect/exploitation/reporting and approaches/dealing with combative residents.

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Observation on 6/17/19 at 11:43 AM revealed Resident #130 was sitting in recliner with eyes closed, in the spa therapy room, groomed in personal clothing with one staff in the spa therapy room with Resident #130 and 3 other residents. Continued observation revealed no concerns of abuse.

Observation on 6/17/19 at 11:55 AM revealed Resident #130 was sitting in the dining room, groomed in personal clothing, sitting at a table with one other resident; staff interacting and talking with the resident. Further observation revealed staff delivered a meal tray to the resident and the resident was observed smiling and interacting with staff.

Observation on 6/18/19 at 8:28 AM revealed Resident #130 was sitting in a wheelchair in the dining room eating the breakfast meal with 3 other residents at the table, and 2 staff were assisting residents with the breakfast meal. Further observation revealed Resident #130 was groomed in personal clothing and assisting self with the meal. Continued observation revealed no concerns of abuse.

Telephone interview with Licensed Practical Nurse #3 on 6/18/19 at 6:02 PM revealed, when she walked into Resident #130's room she witnessed CNT #5 smack the resident on both arms. Further interview revealed Resident #130 was lying in the bed and CNT #5 was trying to get the resident's arms back through the sleeves of the resident's shirt and the resident was combative. Further interview revealed LPN #3 immediately called CNT #5 out into the hallway. Further interview LPN #3 stated "I called LPN #4 to the hallway to witness me confronting CNT#5; I

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F 600	Continued From page 4	F 600		

said I saw what you done and she [CNT #5] said I'm sorry." Continued interview revealed LPN #3 and LPN #4 immediately removed CNT #5 from resident care and from the facility. Further interview revealed LPN #3 contacted the Unit Manager and began skin assessments and interviews with residents. Continued interview with LPN #3 revealed no concerns with abuse training.

Telephone interview with CNT #5 on 6/18/19 at 6:22 PM revealed while she was attempting to put the resident's arms in the resident's shirt sleeves the resident "tapped" her [CNT #5] arm and she stated she said "ouch". Further interview revealed when CNT #5 reached over the resident's left arm she stated, "I accidently tapped her on the left shoulder; I did not hit the resident." Further interview revealed LPN #3 told CNT #5 to clock out and go home. Further interview revealed CNT #5 clocked out and left the facility. Continued interview with CNT #5 revealed no concerns with abuse training.

Interview with LPN #4 on 6/19/19 at 9:33 AM in the 1 North dining room revealed LPN #3 motioned for LPN #4 to come to hallway where LPN #3 and CNT #5 were. When LPN #4 arrived on the hallway LPN #3 informed LPN #4 she witnessed CNT #5 striking Resident #130. Further interview revealed LPN #3 and LPN #4 removed CNT #5 from resident care and contacted the Administrator. Further interview revealed LPN #4 walked CNT #5 out of the building, assessed Resident #130 and other residents with no apparent injury noted to any residents. Continued interview revealed interviews were conducted with residents with no concerns of abuse identified. Further interview

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F 600	Continued From page 5	F 600		

revealed LPN #4 had never witnessed CNT #5 have any altercations with residents and residents had no complaints about the care CNT #5 provided. Continued interview revealed no concerns with trainings on abuse.

Interview with the Director of Nursing (DON) on 6/19/19 at 2:01 PM in the chapel revealed she received a phone call from the Unit Manager regarding LPN #3 witnessing CNT #5 slap Resident #130. Further interview revealed she [DON] immediately came to the facility. Further interview revealed when she arrived at the facility CNT #5 was already removed from the building by LPN #3 and LPN #4. Further interview revealed the DON started an investigation, conducted skin assessments and interviews including skin assessment on Resident #130. Further interview revealed Resident #130 did not have any areas "not even a pink mark." Further interview revealed the DON contacted the resident's family and physician. Further interview revealed the resident's medical physician and psychiatric physician assessed the resident and the resident did not have any adverse effects from the incident. Further interview revealed the DON immediately began in-servicing the staff on abuse and on how to handle combative residents.

Interview with the Administrator on 6/19/19 at 7:28 PM in the conference room revealed when asked how she ensured the residents were kept free from abuse she stated by ensuring staff were screened for abuse before hire and staff were in-serviced on abuse 4 times yearly and as needed. Continued interview revealed staff were trained to report abuse immediately and staff were required to report abuse to state agencies within 2 hours. Continued interview revealed she

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F 600	Continued From page 6 was notified immediately concerning the incident involving resident #130 and CNT #5. Continued interview revealed CNT #5 was immediately removed from resident care, suspended and terminated.	F 600		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview	F 657	**F657 Care Plan Timing and Revision** McKendree Village will continue to ensure that resident's comprehensive care plans are updated regularly and reflect the resident's current needs. Resident 73 had their care plan updated on 6/28/2019 to reflect that transfers will occur utilizing two staff by Hoyer lift. On or before 7/12/2019, the nursing staff (to include RNs, LPNs, and CNAs) will attend an in-service. The in-service will be conducted by the DON, Administrator, or Designee, and will include: • Review of the regulation. • Review of the statement of deficiency. • Review of the plan of correction. • Review of the facility Transfers Utilizing Mechanical Lift and Comprehensive Care Planning Policies to ensure transfer assistance by mechanical lift is care planned. Any resident who requires utilizing a mechanical lift for transfers had their care plans reviewed to ensure a mechanical lift with the assistance of two staff was captured on the care plan. This was completed on 6/28/ 2019. Residents who have a change in condition and subsequently require the use of a mechanical lift for transfers will be discussed during the clinical meetings and the Interdisciplinary Team will ensure that the bedside care plan has been updated to reflect this change.	8/2/2019

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F 657	Continued From page 7 the facility failed to revise a care plan to reflect the usage of a lift for 1 of 58 residents (#73) reviewed which resulted in a fall. The findings include: Medical record review revealed Resident #73 was admitted to the facility on 11/30/16 with diagnoses which included Chronic Obstructive Pulmonary Disease, Anxiety and Muscle Weakness. Medical record review of the undated bed side care plan revealed Resident #73 required 2 persons for assist with transfers. Medical record review of the care plan dated 11/7/18 revealed "...Assist x 2 with Transfers..." Medical record review of the Quarterly Minimum Data Set (MDS) dated 11/1/18 revealed Resident #73 required extensive assistance with 2 staff members for transfers. Medical record review of the post fall investigation dated 12/5/18 revealed "...I was in the patients room using the Sara Lift to stand him up to change his brief..." Interview with Registered Nurse (RN) #5 on 6/18/19 at 5:23 PM at the nurse station on 2 North revealed the resident lift status was documented on the bed side care plan and what type of lift was to be used for Resident #73. Continued interview confirmed when asked to review the bedside careplan revealed the "lift type" was not marked, indicating a lift was not required to transfer Resident #73. Interview with the Administrator on 6/19/19 at	F 657	Beginning 7/23/2019, the Administrator or Designee will monitor for continued compliance through the Quality Improvement audits (see Attachment C). The audits will be completed weekly for one month and monthly for one quarter. The Administrator or Designee will report to the Quality Assurance Performance Improvement Committee who will determine the frequency of further monitoring.	

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F 657	Continued From page 8 7:34 PM in the conference room confirmed "... the care plan should have been updated and made patient specific..."	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to prevent an accident for 1 of 58 residents (#73) reviewed related to not having 2 staff members operating a lift during a transfer. The findings include: Review of the facility policy Lifting and Machine, Using a Mechanical revised 2017 revealed "...At least two (2) nursing assistants are needed to safely move a resident with mechanical lift..." Medical record review revealed Resident #73 was admitted to the facility on 11/30/16 with diagnoses which included Chronic Obstructive Pulmonary Disease, Anxiety and Muscle Weakness. Medical record review of the undated bed side care plan revealed Resident #73 required 2 persons for assist with transfers.	F 689	**F689 Free of Accident Hazards/Supervision/ Devices** McKendree Village will continue to ensure that residents comprehensive care plans are updated and reflect the resident's current needs. Resident 73 had their care plan updated on 6/28/2019 to reflect that transfers will occur utilizing two staff by Hoyer lift. On or before 7/12/2019, the Health Center nursing staff will attend an in-service. The in-service will be conducted by the DON, Administrator or Designee, and will include: • Review of the regulation. • Review of the statement of deficiency. • Review of the plan of correction. • Review of the facility policy regarding "Transfers Utilizing Mechanical Lift." The Certified Nursing Assistant was provided with 1:1 education by the Director of Nursing on 6/28/19 reviewing that all residents utilizing a Hoyer lift for transfers require a 2-person assist. The Director of Nursing or Designee will perform audits on residents who utilize a mechanical lift for transfers to ensure proper technique and policy are being followed. This audit will occur weekly x4 weeks, then bi-weekly x4 weeks, then monthly x2 months. Beginning 7/23/2019, the Director of Nursing will present the findings of the audits to the Quality Assurance Performance Improvement Committee x4 months for review and/or further recommendations.	8/2/2019

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F 689	Continued From page 9	F 689		

Medical record review of the care plan dated 11/7/18 revealed "...Assist x 2 with Transfers..."

Medical record review of the Quarterly Minimum Data Set (MDS) dated 11/1/18 revealed Resident #73 required extensive assistance with 2 staff members for transfers.

Medical record review of the Fall Documentation dated 12/5/18 revealed "...The tech was trying to get the Resident up in the stand uplift to change his briefs, the Resident slipped down the floor from the recliner..."

Medical record review of the Post Fall Investigation dated 12/5/18 for Resident #73 revealed "...I [Certified Nurse Technician (CNT) #7] was in the patients room using the Sara Lift to stand...up to change brief...I hooked...up on the L [left] side and attempted to hook the R [right] side of the sling...slid off...recliner and I lowered...to the floor..."

Interview with CNT #7 on 6/18/19 at 4:43 PM in the conference room revealed the CNT could not recall who assisted her with Resident #73 when operating the lift stand.

Interview with the Unit Manager on 6/18/19 at 5:23 PM at the nurse station revealed the Unit Manager could not remember the staff who assisted Resident #73 with the lift on 12/5/18. Continued interview revealed if there were 2 CNT members assisting Resident #73 "...there should be another statement for the other CNT..." Continued interview confirmed "...if CNT #7 was using the lift then there should have been 2 people..."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 Telephone interview with Registered Nurse (RN) #6 on 6/18/19 at 7:19 PM revealed RN #6 could not remember if CNT #7 had another CNT with her at the time of Resident #73's fall. Continued interview with RN #6 revealed when she arrived to Resident #73's room to assess the resident there were 2 CNT's in the room. Interview with the Administrator on 6/19/19 at 7:34 PM in the conference room confirmed the staff were to follow the care plan when caring for Resident #73.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation and interview, the facility failed to store foods in safe	F 812	**F812 Food Procurement Store/Prepare/Serve-Sanitary** McKendree Village has and will continue to ensure that all food is stored in a sanitary manner with labels and open dates. All out of date food will be disposed of. All food items identified to be without a label, date opened notation, or that were identified as being expired was disposed of as identified on June 17, 2019. On or before 7/12/2019, the dietary staff will attend an in-service. The in-service will be conducted by the Administrator or Designee, and will include: • Review of the regulation. • Review of the statement of deficiency. • Review of the plan of correction. • Review of the facility Food Receiving, Labeling and Storage Policy. An audit of all food items in the kitchen was completed by the Executive Chef and Director of Dining Services and any food found to be without a label, date opened or expired was disposed of. This was completed on 6/17/2019.	8/2/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445491	A. BUILDING _____ B. WING _____	06/19/2019

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F 812	Continued From page 11 and sanitary manner as evidenced by expired, unlabeled and undated foods. Review of the facility policy, Refrigerators and Freezers for storage, labeling and dating foods, revised December 2014, revealed "...All food shall be appropriately dated to ensure proper rotation by expiration dates...Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage... "Use by" dates will be completed with expiration dates on all prepared food in refrigerators...Expiration dates on unopened food will be observed and use by dates indicated once food is opened..." Observation on 6/17/19 at 9:06 AM in the kitchen with the Food Service Executive Chef present revealed the following in the Walk-In Dairy Cooler: 3 Pint containers of tomatoes opened and undated. Observation on 6/17/19 at 9:16 AM in the kitchen with the Food Sercive Executive Chef present revealed the following in the Large Walk-In Cooler: 1-Gallon container of Caesar salad dressing with expiration date of 4/2019;1-Gallon container Mild Cherry Peppers with expiration date of 4/2/19. Further observation revealed a 3-pound (lb) Turkey Bacon package opened and undated; 1-10 lb bag sausage patties opened and undated; 1-10 lb bag Pork Sausage Links opened and undated; 1-16 lb container Cream Cheese Icing opened and undated; 1-11 lb container Chocolate Fudge Icing opened and undated. Observation on 6/17/19 at 9:30 AM in the kitchen with the Food Service Executive Chef present revealed the following in the walk-in Freezer:	F 812	Beginning 7/23/2019, the Administrator or Designee will monitor for continued compliance through the Quality Improvement audits (see Attachment D). The audits will be completed weekly for one month and monthly for one quarter. The Administrator or Designee will report to the Quality Assurance Performance Improvement Committee who will determine the frequency of further monitoring.	8/2/2019

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F 812	Continued From page 12 2-5lb bags - Chicken breast pieces, opened and undated;1-5lb bag Chicken Cordon Bleu, opened and undated;1-10lb bag Hot dogs with obvious freezer burn, opened and undated;1-20 lb bag Chocolate chip cookies, opened and undated;1-10 lb container Frozen Dough Puff Pastry, opened and undated;1-10lb bag Fish (Cod Loins), opened and undated; 1- 5lb bag Pepperoni, expired 3/2016;1-10lb bag Swaifish, expired on 9/26/18. Observation on 6/17/19 at 10:12 AM in the kitchen with the Food Service Executive Chef present revealed the following in the Emergency Food Storage room: 6 cans-7lb Vanilla Pudding, expired May 8, 2019; 3 cans-7lb Chocolate Pudding, expired June 8, 2019; 5 cans- 6lb Tropical Fruit Salad, expired May 2019. Observation on 6/17/19 at 10:30 AM in the kitchen with the Food Service Executive Chef present revealed the following in the Dry Food Storage Room: 10 packets Breakfast Essentials 12.6 ounce (oz), expired November 2016; 1 box Honey Cornbread, expired April 2017; 7 bags - Angel Hair Pasta - 2lb bags, expired April 2018; 1 Box Krusteaz 15.7 oz, expired 7/21/18; 1 Box Gluten Free Cookie Mix 16oz, expired 7/12/18; 1 box - 200 count each Easy Mix Thickener - 4.2 oz packages, expired 11/7/18; 2 boxes - 200 count each - Thickener, expired May 2019; 11 bottles Breakfast Syrup 14.5oz, expired Jan 29, 2019; 1 Box Fusilli Pasta 1 lb, expired 3-5-19. Interview with the Executive Food Service Chef on 6/17/19 at 09:30 AM confirmed, "I would not expect to find open and undated food or expired foods in any coolers, freezers and/or storage areas."	F 812		

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F 812	Continued From page 13 Interview with the Food Service Executive Chef on 6/17/19 at 10:15 AM confirmed, "foods in Emergency Storage are to be checked on a regular basis and rotated with first in first out method of rotation to prevent expired foods." Interview with the Food Service Executive Chef on 6/17/19 at 10:30AM in the Dry Foods storage room confirmed, "storage areas are to be checked for expiration dates on a regular basis to prevent expired foods." Interview with the Food Service General Manager on 6/18/19 at 08:30AM confirmed, "I would not expect to find opened unlabeled and undated food or expired foods in any area where food is stored" Interview with the Kitchen Supervisor on 6/18/19 at 08:45 AM confirmed, "I would not expect to find expired foods in any storage area and staff were to label and date foods upon opening."	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880	**F880 Infection Prevention & Control** McKendree Village will ensure that the dryer compartments are cleaned daily. The laundry facility and equipment were thoroughly cleaned, and all lint was removed from the dryer vents on June 19, 2019. The fan in the laundry area was removed on June 19, 2019.	8/2/2019

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F 880	Continued From page 14 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	On or before 7/12 /2019, the housekeeping staff will attend an in-service. The in-service will be conducted by the Director of Facilities or Designee, and will include: • Review of the regulation. • Review of the statement of deficiency. • Review of the plan of correction. • Review of the facility Environmental Services Laundry Policy. • Process for documenting the cleaning of dryer lint traps The Dryer Lint Cleaning Log is located centrally in the laundry and staff will sign daily after cleaning the dryer compartment of lint. Beginning 7/23/2019, the Administrator or Designee will monitor for continued compliance through the Quality Improvement audits (see Attachment E). The audits will be completed weekly for one month and monthly for one quarter. The Administrator or Designee will report to the Quality Assurance Performance Improvement Committee who will determine the frequency of further monitoring.	8/2/2019

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F 880	Continued From page 15	F 880		

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on the facility policy review, observation and interview, the facility failed to store linens to prevent the spread of infection.

The findings include:

Facility policy review, Cleaning Laundry Room, undated, revealed "..to provide adequate guidelines for cleaning laundry rooms...dust ceilings, lights, vents, spot clean walls, doors, furniture, etc..."

Observation on 6/19/19 at 1:30 PM of the laundry room with the executive Director and the Housekeeping and Laundry Supervisor revealed an excessive amount of lint between two dryers, on the ceiling, the doors, walls, air vents and in the dryer. Further observation in the clean laundry room revealed a dirty fan in the laundry area blowing air on the clean linen.

Observation on 6/19/19 at 1:30 PM of two of four dryers in the laundry room were labeled,"Urgent, clean lint compartment daily."

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F 880	Continued From page 16 Observation on 6/19/19 at 1;45 PM of the Dryer Lint Cleaning Log revealed the staff had signed the log with no sequencial dates. Continued observation of the cleaning log revealed, "Dryer must cleaned after every load." Interview with the Supervisor of House Keeping and Laundry on 6/19/19 at 1:45 PM in the laundry room he stated, "the dryer lint vents were cleaned every other day." Interview with the Director of Facility Environmental Services on 6/19/19 at 2:00 PM in the laundry room confrmed the laundry staff were responsible for cleaning the laundry room and he expected the laundry room to be clean.	F 880		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on facility policy review, facility documentation, observation and interview, the facility failed to maintain equipment in a safe operating condition related to the kitchen dairy cooler door not sealing and broken door latch, the kitchen large walk-in cooler with a broken door latch, and dryer lint build up with visible lint on the vents, between the dryers, and in the dryer drums. The findings include: Facility policy review, Work Requests, revised	F 908	**F908 Essential Equipment, Safe Operating Condition** McKendree Village has and will continue to maintain all mechanical, electrical, and patient care equipment in safe operating condition. McKendree Village Maintenance personnel attempted to repair the Dairy Cooler and the Large Walk-in Cooler in the Kitchen with the parts that were ordered and received on 6/20/19. Once new parts were installed it was found that the doors still would not latch and seal all the way around the doors. The facility Director of Maintenance has requested bids to replace the doors. Doors will be ordered by 7/12/19. All other cooler and freezer doors were inspected, and no other deficiencies were found.	8/2/2019

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F 908	Continued From page 17 9/24/14, revealed "...To maintain facilities in prime condition by reporting and requesting building/facility repairs according to established procedures..." Review of the Facility Work Order form dated 6/18/19 revealed "...check cooler doors, ordered new latch sets and door gaskets, will repair when parts arrive...the latch parts were ordered and were to be delivered on 6/20/19...the gasket parts were ordered and were to be delivered on 6/20/19..." Observation on 6/17/19 at 9:06 AM in the kitchen with the Food Service Executive Chef present revealed the Walk-in Dairy Cooler door not sealing and the outside latch was broken. Observation on 6/17/19 at 9:15 AM in the kitchen with the Food Service Executive Chef present revealed a gap between the door and frame in which light was seen from inside to outside of the walk-in cooler. The Door facing was worn with no groove to hold the door. Interview with Food Serviced Executive Chef on 6/17/19 at 9:16 AM in the kitchen he stated "Maintenance was aware of the issue with the dairy cooler and the large walk-in cooler and is working on it." Observation on 6/18/19 at 8:25 AM in the kitchen with the Food Service Executive Chef present revealed the latch and seal to the Dairy Cooler and the latch to the Large Walk-In Cooler was not repaired. Interview with Maintenance Director on 6/18/19 at 9:00 AM in the hallway outside of the kitchen	F 908	On or before 8/2/2019, the Dietary and Healthcare Maintenance staff will attend an in-service. The in-service will be conducted by the Director of Facilities or Designee, and will include: • Review of the regulation. • Review of the statement of deficiency. • Review of the plan of correction. • Review of the process for reporting broken equipment and submitting a work request to the Facilities Management Department. Beginning on or before 8/2/19 the Maintenance Supervisor or Designee will monitor cooler and freezer doors during Facilities Management's monthly preventive maintenance rounds. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor (see Attachment F). The Facilities Management Director will report any trends or patterns to the QA/QI committee who will determine the frequency of further monitoring. McKendree Village will ensure that the dryer compartments are cleaned daily. The laundry facility and equipment were thoroughly cleaned, and all lint was removed from the dryer vents on June 19, 2019. The fan in the laundry area was removed on June 19, 2019. On or before 7/12 /2019, the Laundry/Linen staff will attend an in-service. The in-service will be conducted by the Director of Facilities or Designee, and will include: • Review of the regulation. • Review of the statement of deficiency. • Review of the plan of correction. • Review of the facility Environmental Services Laundry Policy. • Process for documenting the cleaning of dryer lint traps	8/2/2019

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F 908	Continued From page 18 confirmed no work orders had been sumbitted by the Food Service Executive Chef for the repairs on the dairy and large walk-in coolers prior to 6/17/19. Facility policy review for Cleaning Laundry Room, undated, revealed "...To provide adequate guideline for cleaning laundry rooms "...dust, ceilings lights and vents...wipe down machines, dryers, included..." Observation on 6/19/19 at 1:30 PM of the laundry room with the executive Director and the Housekeeping and Laundry Supervisor present revealed an excessive amount of lint between two dryers, on the ceiling, the doors, walls, air vents and in the dryer. Observation on 6/19/19 at 1:30 PM of two of four dryers in the laundry room were labeled,"Urgent, clean lint compartment daily." Review of the Dryer Lint Cleaning Log in the laudry room on 6/19/19 at 1:45PM revealed log sheets were dated between 8/6/18-6/17/19. Continued review revealed the staff had signed the log on a random basis. Continued review revealed "Dryer must be cleaned after every load." Interview with the Supervisor of House Keeping and Laundry on 6/19/19 at 1:45 PM in the laundry room he stated, "the dryer lint vents were cleaned every other day." Interview with the Director of Facility Environmental Services on 6/19/19 at 2:00 PM in the laundry room confrmed the laundry staff were responsible for cleaning the laundry room and he	F 908	The Dryer Lint Cleaning Log is located centrally in the laundry. Staff will clean the dryer vent daily and will complete the log after cleaning the dryer compartment of lint. Beginning 7/23/2019, the Administrator or Designee will monitor for continued compliance through the Quality Improvement audits (see Attachment G). The audits will be completed weekly for one month and monthly for one quarter. The Administrator or Designee will report to the Quality Assurance Performance Improvement Committee who will determine the frequency of further monitoring.	8/2/2019

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F 908	Continued From page 19 expected the laundry room to be clean.	F 908		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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E 000	Initial Comments	E 000		

An emergency preparedness survey was completed on 6/19/19 at McKendree Village. No deficiencies were cited under FED-E-1.00.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sylvia J Burton	Interim Administrator	7/11/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

McKendree
MDS Assessments and Capturing of Incidents

Date	Date of Resident Incident?	Resident Name	Was an MDS Assessment completed?	Did the MDS capture the incident?	If it did not, was a correction completed? What was the date of the correction?	Signature

McKendree
Abuse Allegations

Date	Have there been any allegations of abuse? Y/N	If yes, who was the resident(s)?	Was the incident reported to the Abuse Coordinator immediately? Y/N	Was the abuse policy followed? Y/N	Was a SRI completed within the state timeframe? Y/N	Was a thorough investigation started and completed? Y/N	Signature

McKendree
Care Plan Updates

Date	Resident Name	Does the resident have a care plan in place? Y/N	Did the resident have an incident? Y/N	Date of Incident.	Was the care plan updated to reflect those changes? Y/N	Were there any concerns found? If yes, was education provided and documented?	Signature

McKendree
Food Storage

Date of Audit	Food is covered and labeled. Y/N	Food has a "Use By" date no later than 3 days after preparing and/or opening? Y/N	Note any concerns and what was done to correct.	Signature